

Rehabilitating the Medical Board's Diversion Program

by Julianne D'Angelo Fellmeth



What if your doctor were an alcoholic? A drug addict? What if he stole narcotics from his hospital's supply, self-injected while on duty, and practiced medicine while under the influence?¹ Can you think of any-one more dangerous to wield a scalpel, administer anesthesia, or suture your child?

Addiction to alcohol or drugs is a chronic, lifelong disease in which relapse and recidivism are expected.² Called "an occupational hazard" for health care professionals by one of the nation's leading experts,³ addiction among physicians is a serious and growing problem.

Physicians may be particularly susceptible to substance abuse problems due to the stresses of working in a health care environment, enhanced access to controlled substances, and an income level that permits them to purchase drugs if necessary. Although the existence of this problem is not disputed, its reach and scope are the subject of some debate:

- "The AMA conservatively estimates that one of every ten practicing physicians in this country becomes seriously impaired."⁴
- "The incidence of impaired physicians is much higher than we had originally perceived. It is apparent now that fourteen to fifteen percent of physicians at some point in his or her career will become impaired. Of these impaired physicians only six to eight percent have primary psychiatric disease."⁵
- "In 1964, Modlin and Montes noted that estimates of the incidence of narcotic addiction in physicians varied from 30 to 100 times that found in the general population, and they classified such addiction as an occupational hazard."⁶

What if the Medical Board—the state agency charged with consumer protection as its highest priority—knew about such physicians, refused to tell consumers, and let those physicians continue to practice medicine while attempting rehabilitation and recovery?

Meet the Diversion Program of the Medical Board of California. This legislatively-created program "diverts" physicians who are abusing or addicted to drugs or alcohol from the disciplinary track (which might revoke or suspend their

medical licenses) into an in-house, Board-sponsored monitoring program subsidized with \$800,000 annually in licensing fees paid by all California physicians. Participation in the Diversion Program is absolutely confidential; "successful" participants are immunized from disciplinary action for self-abuse of drugs or alcohol; and many physicians enter and complete the Program without any interruption whatsoever in their medical practice.

Supporters argue that the Diversion Program protects the public by identifying impaired physicians, providing them with access to appropriate intervention programs and treatment services, and monitoring them for several years to ensure they have recovered and are consistently capable of safe practice. According to Dr. Gene Feldman, who was president of the Medical Board during 1980 when the Program

was created, "the Diversion Program was enacted because a lot of doctors who came before us in discipline had hurt no one but themselves through the disease of substance abuse/chemical dependency. They were being disciplined at an average cost of \$30,000 per case, and most had already gone into rehabilitation programs and were clean and sober. But we were required to discipline them and ruin their lives."⁷ Dr. Feldman and others envisioned the Program as being cheaper than discipline and more protective of consumers, in that it could immediately remove an impaired physician from practice if necessary (whereas the discipline system at that time lacked any meaningful interim remedies).

Has that vision been realized? Over the past five years, the Center for Public Interest Law (CPIL) has expressed repeated concerns about the structure, functioning, and operations of the Medical Board's Diversion Program.⁸ CPIL has registered several levels of concern about the Program, ranging from the philosophical to the structural to the operational.

In 1998, the Board's Division of Medical Quality finally created a task force to investigate CPIL's claims. To assist that task force, the Medical Board, and the California Legislature in reforming this program which is of critical importance to patient protection, we present the following facts and criticisms.

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Diversion Program Purpose and Structure

The Medical Board of California (MBC) is the state agency charged with regulating physicians.⁹ MBC licenses physicians,¹⁰ establishes standards for the practice of medicine in California,¹¹ and enforces those standards through its enforcement program.¹² By statute, MBC consists of twelve physicians and seven non-physicians.¹³ Seventeen of the Board's nineteen members (including all of the physician members) are appointed by the Governor; one public member is appointed by the Senate Rules Committee, and the remaining public member is appointed by the Assembly Speaker.¹⁴ MBC is divided into two autonomous divisions: the Division of Licensing (DOL) and the Division of Medical Quality (DMQ).¹⁵

DMQ is responsible for overseeing the Board's enforcement program, which receives and investigates complaints against licensed physicians,¹⁶ and directs the Health Quality Enforcement Section within the Attorney General's Office¹⁷ to file formal charges and prosecute disciplinary cases against physicians at evidentiary hearings presided over by administrative law judges of the Office of Administrative Hearings.¹⁸ Following the hearing, DMQ members review proposed decisions written by ALJs and make final disciplinary decisions.¹⁹ DMQ also adopts regulations and establishes policy governing MBC's enforcement program.²⁰

DMQ is also charged with establishing criteria for and overseeing the operation of the Board's Diversion Program.²¹ The Legislature created the Diversion Program in 1980 and charged it with "identifying and rehabilitating physicians...with impairment due to abuse of dangerous drugs or alcohol...affecting competency so that physicians...so afflicted may be treated and returned to the practice of medicine *in a manner which will not endanger the public health and safety.*"²² The Legislature further specified its intent about the priorities of the Diversion Program in 1990, when it enacted Business and Professions Code section 2229; that provision states that "[p]rotection of the public shall be the highest priority for the Division of Medical Quality....*Where rehabilitation and protection are inconsistent, protection shall be paramount.*"²³

How does the Diversion Program work? Physicians who abuse drugs or alcohol may voluntarily "self-refer" into the Diversion Program, in which case their participation remains confidential from the Board's Enforcement Program and the public.²⁴ Alternatively, DMQ may require a physician to participate in the Diversion Program as a condition of probation or in settlement of a disciplinary proceeding.²⁵ The Program enters into an individualized contract with each participant. The contract may require the participant to temporarily cease the practice of medicine; it also specifies numerous terms and conditions of participation, including requirements for random bodily fluid testing, mandatory group meeting attendance, physical, psychiatric, psychological, and competency testing, and worksite monitors if the participant is permitted to practice medicine. The goal of the various Diversion

Program "players"—all of whom are described below—is to ensure compliance with the terms of the contract.

Those who "successfully complete the Program"²⁶ are immune from disciplinary action for self-abuse of drugs or alcohol, which otherwise is unprofessional conduct and grounds for discipline by the Board.²⁷ Noncompliance with the terms of a Diversion Program contract is grounds for termination from the Program, and risks exposure to disciplinary action for self-abuse of drugs and alcohol under Business and Professions Code section 2239.²⁸

The "Players"

Division of Medical Quality

Unlike diversion programs for substance-abusing licensees at other California occupational licensing agencies, the Legislature structured the Medical Board's program to be operated and administered internally. With regard to the Diversion Program, DMQ is expressly charged with the following duties:

- ensuring that protection of the public is the Program's highest priority ("where rehabilitation and protection are inconsistent, protection shall be paramount");²⁹
- establishing regional Diversion Evaluation Committees (see below) and appointing their members;³⁰
- establishing criteria for "the acceptance, denial, or termination of physicians" from the Diversion Program;³¹
- establishing criteria for the selection of "administrative physicians" who examine physicians requesting admission into the Diversion Program;³²
- requiring each Diversion Evaluation Committee to submit a biannual report including information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance, and a cost analysis of the program;³³ and
- "administering the provisions" of the statutes creating the Diversion Program.³⁴

Thus, the Division of Medical Quality retains policy-making authority over the Diversion Program. However, it has no role in decisionmaking as to individual participants or the terms of their Diversion Program contracts.³⁵ This important function of the Diversion Program is carried out by local-level Diversion Evaluation Committees.

Diversion Evaluation Committees

The Diversion Evaluation Committees (DECs) are regional committees created in statute.³⁶ Currently, a total of five DECs operate in California; two convene in the Berkeley area, and three in Los Angeles. DEC members are appointed by DMQ. DECs must consist of three licensed physicians and two non-physicians;³⁷ all DEC members must have "experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse...."³⁸ DECs meet quarterly, and are charged by statute with the following activities:

- evaluating physicians who request participation in the Diversion Program;
- reviewing and designating treatment facilities to which Diversion Program participants may be referred;
- receiving and reviewing information concerning physicians participating in the Diversion Program;
- considering whether a participant "may with safety continue or resume the practice of medicine";
- setting forth a written treatment program for each participant, including requirements for group meeting attendance and other "supervision and surveillance";
- holding "a general meeting at least twice a year, which shall be open and public," to evaluate the Program's progress, review data required to be included in reports to DMQ, prepare reports to be submitted to DMQ, and suggest proposals for changes in the Program;³⁹ and
- submitting to DMQ a biannual report which includes "information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance, and a cost analysis of the program."⁴⁰

The DEC's decisionmaking about individual Diversion Program participants is informed and assisted by Diversion Program staff on several levels: (1) local group facilitators who conduct group meetings with Program participants; (2) regional case managers who monitor each participant's compliance with the terms of his/her contract; and (3) Sacramento-based Program management staff.

Group Facilitators

All Diversion Program contracts include required attendance at local meetings conducted by Diversion Program group facilitators. Group facilitators are independent contractors to the Medical Board, not Board employees. Every week across the state,⁴¹ fourteen (14) group facilitators hold meetings of six to twelve participants. Depending on their contract terms, participants may be required to attend one or two group meetings per week. According to the Diversion Program's policy and procedure manual, group facilitators are expected to provide "recovery-oriented psychotherapy which focuses on the use of 12-step programs."⁴² Group facilitators are paid directly by participants at the rate of \$235 per month for two meetings per week, or \$165 for one meeting per week. The facilitators are responsible for convening and facilitating group meetings, recording attendance, observing participants for signs of substance abuse, ensuring the collection of urine samples for testing, and reporting attendance and suspected compliance problems to regional Diversion Program case managers.⁴³

Case Managers

Currently, the Program employs five case managers, each of whom monitors case files on a caseload of 50–60 Diversion Program participants in a specified geographical area; case managers are currently based in Sacramento, the Bay Area, San Bernardino, Glendale, and Orange County. The case

managers receive and review urine test results and reports from group facilitators, hospital well-being committees, and worksite monitors, and ensure that all participants in their caseloads are complying with the terms of their Diversion Program contracts. According to the Diversion Program's policy and procedure manual, case managers are also required to personally interview applicants for admission into the Diversion Program in their assigned geographical area; attend group meetings in their geographical area at least once every two months in order to personally observe Program participants and the group facilitators' performance; and attend DEC meetings when a participant in their caseload appears before the Committee.⁴⁴

Program Manager

The Sacramento-based Diversion Program Manager is a full-time civil service employee of the Medical Board responsible for the overall administration of the Diversion Program. The Program Manager directly supervises compliance activities, data collection, and the activities of all Diversion Program case managers and group facilitators.

Liaison Committee to the Diversion Program

In addition to all the various "players" described above, the Medical Board has added another layer of input not authorized by statute. Shortly after enactment of the law creating the Diversion Program, DMQ and the California Medical Association (CMA) established the "Liaison Committee to the Diversion Program." The Liaison Committee is an advisory body charged with serving as (a) "an information sharing and clarification body regarding Diversion Program policies and procedures; (b) a forum for consideration of information from outside the Program; and (c) a forum for discussion of long-range Program plans."⁴⁵

The Liaison Committee membership includes the chair of each regional Diversion Evaluation Committee; representatives of Diversion Program and MBC executive staff, the California Medical Association (CMA), and the California Society of Addiction Medicine (CSAM); and two members of DMQ.⁴⁶ The Liaison Committee meets quarterly in private. During the public session of each quarterly DMQ meeting, the Diversion Program Manager reports recent significant Liaison Committee actions and recommendations to the Division of Medical Quality. Generally, Diversion Program staff simply implement decisions and recommendations of the Liaison Committee; it is rare for DMQ to review or ratify a recommendation of the Liaison Committee.⁴⁷

Major Diversion Program Issues

As noted above, CPIL is concerned about the Diversion Program on many levels. At the most basic level, DMQ and the Diversion Program have wholly failed to comply with several statutory requirements for the past 18 years. For example:

- Since 1980, Business and Professions Code section 2350(h) has required DMQ to establish criteria for the selection of "administrative physicians"—physicians who

are assigned to perform medical and psychiatric examinations of prospective Diversion Program participants.⁴⁸ DMQ has never adopted those criteria, and has developed no training materials to adequately convey Diversion Program policies, priorities, and procedures to new administrative physicians.

- Since 1980, Business and Professions Code section 2350(i) has required the DEC's to submit biannual reports to DMQ detailing the number of cases accepted, denied, or terminated with compliance or noncompliance, and analyzing the cost of the program. No DEC has submitted a report under section 2350(i) for at least the past five years. Neither Diversion Program staff nor DMQ has ever required one.
- Since 1980, Business and Professions Code section 2352(g) has required each DEC to hold a public meeting twice a year. CPIL has been on the Medical Board's mailing list for 18 years; not once has any DEC ever published notice of such a meeting. Neither Diversion Program staff nor DMQ has ever required the DEC's to comply with this requirement.

These requirements are statutory, and the Medical Board should either comply with them or sponsor legislation to change the statutes. However, even full compliance with these statutes would fail to address the four major flaws of the Diversion Program, which are briefly summarized as follows.

DMQ's Failure to Properly Oversee the Diversion Program

Business and Professions Code section 2346 unambiguously delegates DMQ with the responsibility for overseeing the Diversion Program, for establishing its guiding philosophy, goals, and protocols, and for adopting regulations and administrative policies to guide its day-to-day activities. However, DMQ has never taken ownership of this program. Instead, it created the Liaison Committee in 1982 and has—for all intents and purposes—abdicated its policy-making role and administrative authority over the Program to that Committee. DMQ's "oversight" of the Diversion Program consists of its receipt and review of a two-page statistical report submitted by Program staff at each quarterly DMQ meeting, and its routine approval of staff and Liaison Committee nominations for DEC vacancies.⁴⁹

As noted above, the Liaison Committee is composed largely of private citizens; it meets infrequently and in private, insulated from public scrutiny, comment, and account-

ability. DMQ is not authorized to delegate its policymaking role to private parties, especially in the absence of statutory authorization. Yet it has undeniably done just that—Diversion Program staff interpret Liaison Committee directives and recommendations as orders, and implement them without review or ratification by DMQ.⁵⁰

Due to DMQ's lack of interest, the Diversion Program lacks an overall guiding philosophy which demonstrably protects consumers

from the Medical Board's most dangerous licensees, as required by Business and Professions Code section 2229. It lacks protocols and standards to guide the decisions and actions of the DEC's, the Program Manager, the case managers, and the group facilitators. The Program's enabling act is outdated and vague; its implementing regulations, adopted by DMQ in 1981, are minimal and merely nonsubstantive restatements of the statute; its policy and procedure manual is not law, and DMQ has established no mechanisms to determine or measure compliance with it. No member of DMQ is familiar with the operations of the Program. DMQ has allowed the Program to flounder—unsupervised and standardless—for 19 years.

This criticism is not new, and CPIL is not the first to level it. Three audits during the 1980s all found that the Diversion Program fails to adequately monitor drug- and alcohol-dependent physicians—the *raison d'être* of the Program.⁵¹ As far back as 1982, the state Auditor General found serious deficiencies with the Diversion Program, and opined that they stem "from the lack of established standards and guidelines for terminating participants" and that, "in particular, [the Medical Board] has not clarified the requirement that a physician be terminated from the program when that physician is deemed too great a risk to public health...[Consequently,] there is no assurance that the public is being adequately protected during the process of rehabilitating physicians."⁵² In 1985, the Auditor General repeated this criticism, and described an astounding example of this critical failure: "On four separate occasions over a three-month period, urine samples collected from the participant during his office hours revealed that he was under the influence of alcohol."⁵³ Yet the Program Manager failed to suspend the physician from practicing medicine, and failed to terminate the physician from Program participation.⁵⁴

To this day, DMQ has taken no meaningful actions to establish such standards or otherwise clarify its philosophy about the Diversion Program. It has failed to establish or even discuss criteria which justify termination from the Program, any policy whatsoever for the Program's approach toward

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physicians who relapse into drug or alcohol use, or criteria for required practice cessation. It has failed to address any of the serious operational flaws which have been brought to its attention over the past decade (see below).

The Division must discontinue its delegation of the oversight of the Diversion Program to the Liaison Committee; that committee is neither authorized to nor capable of engaging in such oversight. DMQ must reestablish itself as administrator of the Diversion Program, clearly communicate that role to Diversion Program staff, and redefine the role of the Liaison Committee.

Fragmented Nature of Program Decisionmaking

As described above, Diversion Program decisionmaking—both as to policy and individual participants—is subject to input from a variety of levels: DMQ, the Liaison Committee, the DEC's, group facilitators, and Diversion Program staff. Each of these levels suffers from major flaws. Although DMQ has been delegated the major policymaking role, it has withdrawn and effectively redelegated that function to the Liaison Committee, whose role is nonstatutory and uncertain.

As to the contents of individual participants' contracts and decisionmaking regarding their compliance with those contracts, the statute delegates major responsibility to the DEC's. This is an unfortunate selection. These committees—composed of private citizens—meet on the local level, infrequently, and in private. Although they are composed of individuals knowledgeable of chemical dependency, their decisions are made in a vacuum. Because DMQ has failed to adopt any standards to guide DEC decisionmaking, inconsistency is almost assured. Because DEC decisions are not reported or recorded in any way, no DEC has any idea how another DEC has acted in a similar case. Because neither DMQ nor Program staff review or ratify DEC decisions, the Program lacks a structural check on inconsistent or erroneous decisions. And because the DEC's have failed to comply with Business and Professions Code section 2350(i) by submitting biannual statistical reports, neither Program staff nor DMQ is able to comprehensively monitor the actions of the Program. These local committees—composed of private parties—are shooting from the hip in an attempt to deal with the state's most dangerous physicians. Neither DMQ nor the Diversion Program can assure patients and consumers that the Program's decisionmaking as to these physicians is swift, effective, and consistent, as expressly required by Business and Professions Code sections 2229 and 2340.

The staff of the Program—the Program Manager and the five case managers located all over the state—receive and transmit information from the group facilitators, the DEC's, and the Liaison Committee. But staff make no decisions. According to staff, decisions are made by the DEC's; staff

simply follow the DEC's' orders, made without the benefit of any clear guidelines or regulations established by DMQ.

And because the operations of the Diversion Program are shrouded in secrecy, no one is able to adequately monitor its effectiveness. We are left to rely on "spin" articles written by staff and Liaison Committee members,⁵⁵ incomplete statistical data,⁵⁶ and a misleading "success rate" constantly trumpeted by the Program.⁵⁷

DMQ must gain control of the Diversion Program. It, or an active subset of it (such as a Standing Committee on the Diversion Program), must engage in major policy and procedural decisionmaking and establish monitoring mechanisms to gauge staff's adherence to those policies and procedures. DMQ also must seek legislative repeal of the statutes which

permit the DEC's to determine the terms and conditions of Diversion Program contracts and to make standardless, unsupervised decisions about individual Program participants.

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The Program Permits Private Parties to Exercise State Police Power

Perhaps the most serious structural problem of the Diversion Program lies in the fact that its enabling act delegates state police power decisionmaking authority to private parties. As will be discussed below, this statute is void as unconstitutional and as inconsistent with federal antitrust law.

As noted above, Business and Professions Code section 2352 authorizes the DEC's to engage in several activities, most of which are advisory or recommendatory. However, section 2352(e) authorizes the DEC's to "consider in the case of each physician...participating in the program whether he or she may with safety continue or resume the practice of medicine," and section 2352(f) authorizes the DEC's to "set forth in writing...a treatment program established for each physician...with the requirements for supervision and surveillance." These provisions have been interpreted by the Diversion

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Program to confer absolute, autonomous, and unreviewable decisionmaking authority on the DEC's as to the terms and conditions of each participant's contract, including whether the physician is permitted to practice medicine.⁵⁸ The DEC's also decide the point at which a participant has either "graduated"⁵⁹ or should be "terminated unsuccessfully" from the Program.⁶⁰ No member of the Medical Board or its staff reviews or ratifies the DEC's' decisionmaking.

A determination of the terms and conditions of an occupational license is clearly the exercise of state police power authority—which exercise is reserved to government officials, not private parties. As such, subsections 2352(e) and (f) violate two key legal doctrines: (1) They improperly delegate state police power decisionmaking authority to private parties—a violation of the constitutional principle of separation of powers; and (2) they violate federal antitrust law in that

they permit private parties to collude and restrict the access of a competitor to the marketplace (a "conspiracy to restrain trade" or "group boycott" in antitrust parlance), without adequate state supervision as required by the "state action" exception to antitrust scrutiny.

• **Unlawful Delegation to Private Parties.** The "unlawful delegation" argument is based upon one of the most fundamental tenets of our governmental structure—the separation of powers between the three branches of government. "The doctrine of separation of powers under our form of government, which is expressly stated in the constitution, declares that governmental powers are divided among the three departments of government, the legislative, executive, and judicial, and that persons charged with the exercise of one power may not exercise either of the others except as permitted by the constitution."⁶¹

Explicit in the structure of our government is the notion that one branch may not perform the powers of another branch, and may not delegate its governmental powers to another branch. Implicit in this structure, and *a fortiori*, is the notion that all governmental power must be exercised by government officials, and may not be delegated to non-governmental private parties. Fundamental governmental police powers must be exercised by government officials, not by private parties.⁶²

The DEC's are composed of private parties. DEC members are not appointed by the Governor or other elected officials. They are appointed by DMQ, upon nomination by the Liaison Committee (also composed almost entirely of private parties). No statute or regulation requires them to take an oath, file conflict-of-interest statements with the Fair Political Practices Commission, or become aware of circumstances under which they must recuse themselves from state decisionmaking. DEC members unilaterally determine the terms and conditions under which a state licensee may exercise that license. Neither the Legislature nor the Division of Medical Quality has articulated standards to guide the DEC's exercise of discretion as to the terms of any Diversion Program contract. The DEC's decisionmaking is not reviewed or ratified by any member of the Medical Board or its staff.

Thus, Business and Professions Code subsections 2352(e) and (f), as interpreted by the Diversion Program, are unconstitutional. They improperly delegate state police power to private parties, and fail to establish standards to guide the exercise of that power. The statutes should be repealed; state police power decisionmaking should be reserved to duly appointed Medical Board members and its employed professional staff.

• **Antitrust Concerns.** Generally, state and federal antitrust laws preclude combinations in restraint of trade (such as collusion or agreement by entrepreneurs to exclude others in competition).⁶³ An agreement by entrepreneurs to exclude those in competition (which may be accomplished by enforcing a barrier to entry into a profession or by excision from the profession through the enforcement process) is termed a "group boycott" or "concerted refusal to deal." Such behavior, where horizontal in nature, is often considered to be a *per se* violation of federal antitrust law.⁶⁴

Where carried out by combinations of competitors appointed to state occupational licensing boards, such anticompetitive activities are permitted only if they meet the "state action" test.⁶⁵ To qualify for so-called "state action immunity" from the application of federal antitrust law, challenged activities must meet both prongs of a two-pronged test: (1) the restraint of trade must be clearly articulated in state law with the purpose to displace competition; and (2) the restraint must be subject to "active state supervision" by independent officials.⁶⁶

The restraint of trade at issue here is the participation of the members of the DEC's (private parties, three-fifths of whom are physicians) in one of the primary police power functions of the Diversion Program—unilateral decisionmaking as to the terms of a Diversion Program participant's contract and the exercise of his/her professional license. Even assuming this activity meets the first prong of the two-part test described above (in that it is "clearly articulated" in Business and Professions Code subsections 2352(e) and (f)),⁶⁷ the major issue relates to the second prong of the "state action" immunity test: the requirement of active and independent state supervision. Again, this concept rests with the basic notion of unlawful delegation (see above). Even if it wants to do so, "the state" (here, the Legislature and the Medical Board) may not delegate to private interests the role of guardian over a restraint of trade which benefits them. In the leading case of *Midcal*,⁶⁸ the U.S. Supreme Court invalidated a California law allowing liquor distillers to set resale prices and submit them to a state agency (the Department of Alcoholic Beverage Control) for approval. The Court voided the law because the agency, which was required to review the proposed prices on behalf of the general public, routinely rubberstamped the prices submitted by the distillers without exercising *bona fide* independent supervision.

Here, "the state" (the Legislature) has apparently authorized the DEC's to exercise state police power in subsections 2352(e) and (f). However, "the state's" job is not finished. Under *Midcal*, "the state" (the Medical Board) must also exercise "active supervision" over the activities, recommendations, and decisions of the DEC. As noted above, no one at the Medical Board reviews or ratifies DEC decisionmaking regarding the terms of Diversion Program contracts. Nor, under *Midcal*, may such supervision be perfunctory. It must be actual and active supervision, with control and actual decisionmaking vested in public officials accountable to the body politic from which the exercised power derives. Clearly, the second prong of the *Midcal* test is not met, and the Medical Board is exposing itself to significant antitrust liability.

The Secrecy Which Shrouds the Diversion Program

The Diversion Program operates in absolute confidentiality. The Program and its supporters argue that such confidentiality is absolutely essential in order to attract impaired physicians into the Program. However, that intended result has not come to pass—only 200–240 physicians have ever been enrolled in the Program at any given time since 1980.⁶⁹

Consumers should be able to learn whether their physician is abusing or addicted to drugs or alcohol, but no such information is forthcoming from the Medical Board. And—as mentioned above, the Program maintains confidentiality of physician participation not only from the public, but from the Board's own Enforcement Program. This is particularly troublesome when the Diversion Program requires a participant to agree not to practice medicine, but does not communicate such agreement to the Enforcement Program. If Enforcement thereafter receives a complaint or report about such a physician which indicates that the physician is in fact practicing medicine, it will not detect this violation of the agreement. Nor will the Diversion Program, because it has no monitoring mechanism to detect whether a physician who has agreed to cease practice has in fact resumed practice.

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If the Diversion Program had a sterling record of effectiveness and accountability, some level of secrecy might be tolerated. However, as noted above, three separate state audits of the Program during the 1980s all found that the monitoring provided by the Program is deficient,⁷⁰ and no aspect of the Program has been meaningfully changed since then. Because there is confidentiality, there must be accountability. However, instead of confidentiality and accountability, the Medical Board's Diversion Program suffers from no accountability and consumers suffer from its confidentiality.

Operational Deficiencies within the Diversion Program

Other flaws plague the Medical Board's Diversion Program, due largely to the absence of strong Program oversight by the Division of Medical Quality. These deficiencies are briefly catalogued below.

MBC Has Few Mechanisms to Detect Chemical Dependence

As described above, the Diversion Program offers several "carrots" to entice drug- and alcohol-dependent physicians into participation—including immunity from disciplinary action for self-abuse of drugs or alcohol, and confidential participation (neither the Board's Enforcement Program nor inquiring consumers will be told of the participation of physicians who self-refer into the program). However, neither of these mechanisms has succeeded in luring more than 200–240 physicians into the Program at any given time in its 19-year history. Statistically, at least 3,500–4,000 physicians actually experienced drug or alcohol addiction during that period.⁷¹ To have meaningfully addressed this problem, the Diversion Program

should have had a participation rate of at least 2,000 physicians. The Program—with its "graduation" of only 623 physicians since 1980, and the unknown whereabouts of 289 participants who have "unsuccessfully terminated" from the program since 1980⁷²—is not even touching the tip of this very dangerous iceberg. At best, the Program can be said to have addressed 10–15% of the problem.

When questioned by DMQ members about the Program's low participation level, Diversion Program staff frequently note that participation is a "hard sell" because of the Program's structural location within the Medical Board; according to staff, physicians perceive that the in-house Diversion Program may be too closely connected to the Board's Enforcement Program.⁷³

Nor has the Program developed mechanisms to detect chemical dependence or symptoms thereof. While other states' licensure renewal forms require the self-disclosure of, for example, recent charges or convictions of drug- or alcohol-related offenses, MBC's license renewal form does not seek that information.

No Required or Presumed Practice Cessation

Unlike the Board of Registered Nursing⁷⁴ and medical boards in other states,⁷⁵ MBC's Diversion Program does not require a temporary cessation of medical practice during the extensive evaluation necessary to determine the extent of chemical dependency, inpatient or outpatient treatment, or the early and fragile stages of recovery.

After contacting MBC's Diversion Program, a prospective participant is interviewed within two to three days by a group facilitator or case manager. Group meeting attendance begins fairly quickly. Consultation among group facilitators, case managers, and medical consultants at the Medical Board's district (regional) offices begins to flow, and a group consensus develops as to what kind of physical, psychiatric, psychological, neurological, competency, or other

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evaluations the participant should undergo during the next several weeks. Within the next several months, the participant appears before the Diversion Evaluation Committee, which fashions the individualized agreement and gives the participant five days in which to sign it. During this entire time period, however, the participant is usually free to practice medicine (including writing prescriptions); his/her license remains unrestricted and unfettered. The only assured monitoring of that physician is achieved via a group facilitator who conducts twice-weekly group meetings, and twice-monthly urine tests. The Program lacks a requirement or even

a presumption that participants will be asked to immediately cease practice during assessment, treatment, and the early stages of recovery; further, it lacks standards upon which such a decision should be made by any of the various Diversion Program "players."⁷⁶

Frequency of Required Urine Testing

Prior to May 1998, Program policy required participants' urine to be tested only twice per month—and one of those tests occurred at a regularly-scheduled group meeting which could easily be anticipated by the participant. A random urine test was required to be conducted only once per month. In response to CPIL criticism of this practice, the Diversion Program abruptly (and without discussion, review, or ratification by the Division of Medical Quality) changed its policy to require two random tests per month.

This policy—even the changed policy—is insufficient to provide adequate public protection from physicians who are permitted to practice medicine and are at risk of relapse. Physicians who are admitted alcoholics or addicts, who are at the early stages of recovery, and who are *permitted to continue practicing medicine* should be random-tested several times per week to ensure that they have not relapsed.

The DEC's "Monitoring" of Diversion Program Participants

The DEC's are not structured or resourced to provide adequate monitoring of Diversion Program participants. As noted above, DEC members are volunteers with other jobs and livelihoods. The DEC's meet only once every three months, and must determine (a) whether a physician should be formally admitted into the Diversion Program, and (b) whether the physician should be permitted to practice medicine, and under what conditions, on the basis of one meeting with the participant. Of significance, the DEC's may not initially meet with the participant (or applicant for participation) for several months after the initial application; prior to this meeting, it is unclear exactly who is meeting face-to-face with the applicant, who is deciding whether the physician is capable of safe practice during rehabilitation, and whether that person is qualified to make that determination. Further, after the initial meeting, the DEC's do not routinely meet with participants. All further "monitoring" is performed by group facilitators, with occasional observation by the case managers.

Program Monitoring of Participants Who Have Agreed Not to Practice

The Diversion Program has no monitoring mechanism to ensure that a physician who has agreed not to practice medicine has in fact ceased practice. The DEC may ask a dangerous physician to voluntarily refrain from practice. However,

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the Program lacks a meaningful enforcement mechanism to detect whether physicians who are dangerous, have been asked not to practice, and have agreed not to practice have in fact resumed practice (including the prescription of drugs for him/herself or others). This is particularly troublesome. Theoretically, the Diversion Program has identified a very dangerous physician—one who is probably using drugs or alcohol and is a threat to patients—and has secured his/her agreement not to practice. But nothing and no one in the Diversion Program can detect whether that physician is in fact practicing.⁷⁷ And,

as noted above, if the Board's Enforcement Program receives a complaint about that physician which indicates that the physician is practicing medicine, it will never know that the complained-of physician is a Diversion Program participant who has agreed not to practice. For the most dangerous physicians who have been asked not to practice, the Diversion Program has no meaningful detection mechanism to ensure compliance.

The Program Lacks a Policy for Handling Relapse

DMQ has adopted very few regulations to implement the Diversion Program's enabling act.⁷⁸ Of particular concern, it has failed to codify any policy whatsoever on its approach toward relapse (also called, in rehabilitation parlance, a "slip" or "remission interruption"). Because of this failure, DEC's lack standards to guide decisionmaking on whether to terminate a participant from the program for failure to comply with the contract.

Many physicians who finally enroll in the Board's Diversion Program have "flunked out" of other rehabilitation programs, and do so only because they know that their practice is at risk, that their drug/alcohol abuse will eventually be detected by patients, colleagues, or co-workers, and that they will become the subject of complaints to the Medical Board. Participation in the Diversion Program should be the physician's last chance—not the first chance in

which violations of the contract terms are repeatedly tolerated. The approach of DMQ and its Diversion Program should not be a "touchy-feely" coddling of addicts, because these are not ordinary addicts. These addicts are physicians—physicians who retain a full and unrestricted license to practice medicine in California, a full and unrestricted license to cause irreparable harm to the people of California. Nevertheless, Diversion Program documents contain repeated references to uncomfortably lax policies which apparently permit repeated relapse without penalty:

- "Problem cases that cannot be resolved with the case consultant are brought to the attention of the DEC for changes in the physician's Diversion Agreement."⁷⁹
- "The case managers regularly review their cases to identify any which may have compliance issues. If any

participant is found to be out of compliance, the case manager will examine the physician's recovery program and work closely with the group facilitator to discover what is going on. When problems arise, necessary action is taken promptly."⁸⁰

- "The case managers have incorporated several procedures to improve the documentation of cases. Notes are prepared at the bottom of each positive urine test that indicates the action taken and whom they contacted to assist them in deciding the action. They are now preparing a written report of all unusual incidents related to a case."⁸¹
- "Each Diversion [Evaluation] Committee meets four times a year. The meetings are held to assess physicians for entry into the Program, determine if a participant is ready to graduate from the Program, and to deal with participants who are not in compliance with their Diversion Agreement."⁸²

The Diversion Program's toleration of repeated violations of contract terms is a clear violation of Business and Profession Code section 2229, which states that protection of the public is the highest priority for the DMQ in exercising its disciplinary authority: "In exercising [its] disciplinary authority,...the division...shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee....Where rehabilitation and protection are inconsistent, protection shall be paramount." In admitting a licensee into the Diversion Program and refraining from disciplining that licensee, the Board is "taking action that is calculated to aid in the rehabilitation of the licensee." But in tolerating repeated violations of the contract, the Diversion Program is violating the last sentence of section 2229—the rehabilitation efforts have failed, and the "paramount" priority of public protection is violated if the Program fails to report the participant to Enforcement after recidivism. Consumers should not be required to tolerate drug/alcohol abuse by their physicians, and they surely should not be required to tolerate recidivism after a second chance. If the Diversion Program does, it should be abolished.

Unlicensed Practice of Therapy

Neither the Legislature nor the Medical Board has ever clarified whether the primary purpose of the Diversion Program is monitoring or therapy.⁸³ This is a significant distinction—especially in terms of the qualifications of persons hired to administer the program. Diversion Program documents circulated in 1993 indicated that the group facilitators who conduct group meetings on the local level are expected to provide "recovery-oriented psychotherapy which focuses on the

use of 12-step programs" in the required group sessions.⁸⁴ If the purpose of the program is therapeutic, the persons providing such therapy should be licensed by the state in a relevant field (e.g., licensed as a psychiatrist, psychologist, licensed clinical social worker, marriage/family/child counselor, or certified as a drug and alcohol abuse counselor). However, not all of the group facilitators "employed" as independent contractors by the Diversion Program are licensed therapists; nor is it clear whether the Diversion Program even requires licensure of its group facilitators. Simply put, if the purpose of the Program is therapy, the Medical Board is authorizing the unlicensed practice of therapy. In failing to clarify the primary role of the Diversion Program, and in permitting unlicensed persons to engage in therapy, DMQ is exposing patients to severe risk and the state to significant liability.⁸⁵

Method of Payment to Group Facilitators

Group facilitators are not MBC employees, but independent contractors to the Diversion Program. They are paid directly by Diversion Program participants, at a rate of \$235 per month for twice-weekly group meetings, or \$165 per month for once-weekly group meetings. Depending on the number of participants for any individual group facilitator, the facilitator's income for conducting two 1.5-hour meetings per week could be quite hefty. A 1993 investigative report found that one of the Program's group facilitators was making over \$7,000 per month for conducting two group meetings per week.⁸⁶ It is arguable that this method of direct payment could cloud the facilitator's objectivity, because reporting a participant's noncompliance with the terms of his/her contract to the DEC or the Diversion Program Manager might lead to termination of a paycheck. CPIL has long urged the Diversion Program to change the method of payment to group facilitators. For example, participants could write a check to the Diversion Program and the Program could pay facilitators a flat rate based on a range number of participants, to eliminate this potential conflict of interest. However, the Diversion Program has declined to change the payment method for group facilitators.

The Program's "Success Rate"

The Medical Board constantly advertises a 69% (or thereabouts) "success rate" for participants of the Diversion Program. This means that 69% of the physicians who are admitted to the Program actually complete it by attending group meetings for three years⁸⁷ and demonstrating sobriety and a commitment to a sober lifestyle.

However, the Program does not monitor or track "graduated" participants in any way, so its 69% "success rate" figure is a statistic without significance. At a 1998 national

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conference on health professional diversion programs,⁸⁸ Dr. Richard Fuller from the National Institute of Alcohol Abuse and Alcoholism admonished some programs for "lying with statistics" about their "success rates," and revealed the ways in which health care boards misleadingly calculate their "success rates": (1) they track and report only on graduates who have a good prognosis (e.g., a stable family environment, employment, an intact social structure) and who are likely to stick with their commitment to sobriety; (2) they report only on "easily located" graduates; this inflates the "success rate" because those who are easily located are generally doing better than those who are difficult to locate; (3) they keep the follow-up period as short as possible, e.g., three months or shorter; (4) they avoid control or comparison groups; (5) they use a liberal definition of "success"; and (6) they rely solely on self-reporting by the graduate; they don't require drug tests or talk to workplace monitors or others in a position to be candid. Dr. Fuller stated that a credible "success rate" would be based on a yearlong (at least) follow-up of all program graduates (not just the easily located ones) which is not based solely on self-reporting and includes random drugs tests and interviews with workplace monitors and others who come in contact with former diversion program participants.

The Medical Board's Diversion Program doesn't bother with any postgraduate monitoring whatsoever. It simply claims a 69% "success rate" based on completion of a basic program which involves very little monitoring and only two random urine tests per month. Such a claim is meaningless.

Suggestions and Solutions

Preliminarily, CPIL is not convinced the State of California should be involved in the personal rehabilitation of a physician, a lawyer, or any other regulated licensee. Rehabilitation is primarily a private sector function. Many private sector organizations offer drug rehabilitation programs, including programs specifically tailored for professionals. There is no reason for state licensing boards to duplicate what the private sector is adequately providing. If a state licensee has problems with drugs or alcohol which affect his/her competence and thereby threaten the safety of his/her patients or clients, it seems that *the state's* role is to take the license until the licensee proves him/herself capable of practicing safely. The licensee is free to avail him/herself of any number of private rehabilitation services, and resume practice if and when he/she proves to the state that he/she is sober and capable of safe practice. It is unclear why the state, at public expense, must bear the cost of the licensee's rehabilitation—particularly when (1)

many are motivated to join the Program because of pending (or perceived possible) disciplinary charges; (2) many are able to practice medicine during rehabilitation—such that they can afford the cost of private monitoring programs; and (3) there is little assured tracking of either those participating in the Program or those who drop out of the Program.

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Diversion Program within the Medical Board with significant enhancements to protect the public. In CPIL's view, the existing Diversion Program is the worst of both worlds. It is a private rehabilitation program functioning within a public agency—a public agency which grants immunity from prosecution for certain offenses and which engages in in-

adequate monitoring both for resumed drug/alcohol use and for resumed practice where such practice has been curtailed—all of which is cross-subsidized with public money.

Obviously, the Legislature could repeal the statutes creating the Diversion Program and get the Medical Board out of the business of personal rehabilitation. If it chooses to retain the program within the Medical Board, the Legislature should strengthen the Diversion Program statutes as follows:

- New laws should require Diversion Program participants to agree, as a condition of admission into the Program, to cease the practice of medicine at least during required multidisciplinary physical and mental evaluations, any necessary inpatient or outpatient drug/alcohol treatment, and the early stages of recovery. The new laws should also require participants to agree to be referred to the Enforcement Program should they breach any term or condition of their Diversion Program contract.
- New laws should require DMQ to take immediate action to adopt regulations to guide the administration of the Diversion Program, especially in the following areas: (1) the development of substantive criteria governing a physician's readiness to return to medical practice; (2) a comprehensive policy on the Program's response to relapse;⁸⁹ (3) the development of substantive criteria for conduct which warrants termination from the Program; and (4) the frequency of required urine testing.
- DMQ should be required to adopt protocols, procedures, and reporting requirements about the decisionmaking of the Diversion Program which staff must follow, and to develop intrusive monitoring mechanisms to enable the Division to ensure that staff is in fact following them.⁹⁰ The Legislature should require DMQ to create a Standing Committee on the Diversion Program within DMQ, and

DMQ should be required to adopt protocols, procedures, and reporting requirements about the decisionmaking of the Diversion Program which staff must follow, and to develop intrusive monitoring mechanisms to enable the Division to ensure that staff is in fact following them.

charge it with continuous and comprehensive monitoring of the Diversion Program.

- The Legislature should repeal or substantially amend the statutes creating DEC's to clarify that DEC's are advisory bodies which have no authority to exercise state police power. Diversion Program staff, directly accountable to the Medical Board's Executive Director and to DMQ for implementing DMQ-adopted policies and protocols, should make all decisions about the terms and conditions of a participant's contract and continued participation in the Diversion Program.
- The Legislature should require the Program to monitor physicians who have agreed not to practice, to ensure that—in fact—they do not practice (including the prescribing of drugs). New laws should require that the identity of physicians who have agreed not to practice be communicated to MBC's Enforcement Program to ensure that violations of that agreement can be detected via consumer complaints or reports by employers.
- The Legislature should require the Medical Board to revise its license renewal form to require renewal applicants to disclose, under penalty of perjury, whether they have been charged with or convicted of offenses involving drugs or alcohol during the prior renewal period; and to develop other methods of obtaining information about drug- and alcohol-related problems or misconduct by licensees.
- The Legislature should reiterate that all Diversion Program group facilitators providing therapy must be licensed therapists or certified drug and alcohol abuse counselors.
- New laws should specify that group facilitators be paid a flat rate for conducting group meetings for Diversion Program participants; and should require Diversion Program participants—to the extent possible, and especially when they are permitted to practice medicine—to pay a much greater share of the overhead costs of the Program than they currently do.
- The Legislature should require the Diversion Program to track all "graduates" for at least one year after release from the Program, to determine the effectiveness of the Program in helping physicians to maintain sobriety. This post-graduate tracking should include self-reporting; interviews with family members, workplace monitors, and others who come in contact with former Diversion Program participants; and random drugs tests. The Program should also track former participants who have "terminated unsuccessfully" from the Program. These data should be examined annually by DMQ and the Legislature, and should be the basis for future decisionmaking about the fate of the Diversion Program.
- Finally, the Legislature should instruct the Bureau of State Audits (formerly the Office of the Auditor General) to take another independent look at the actual practices of the Diversion Program, to determine whether the Program has rectified the very serious problems first identified in 1982.

Conclusion

Despite the number and severity of the problems described above, the Diversion Program continues to exist. Further, it has recently been given jurisdiction over other types of problem cases, and pending legislation would give it even more responsibility—without any significant change in its structure or operations.

Since January 1, 1997, Business and Professions Code section 821.5 has established a new reporting route for hospital peer review bodies that are investigating physicians whom they believe to be suffering from "a disabling mental or physical condition that poses a threat to patient care." Instead of referring these reports to the Medical Board's Enforcement Program under Business and Professions Code section 805, new section 821.5 requires peer review bodies to report these cases to the Diversion Program, and the Program Manager must periodically contact the peer review body to monitor the progress of the investigation.⁹¹ Between January 1997 and June 1998, 26 such investigations were reported to the Diversion Program.⁹²

And at this writing, Senate Bill 1045 (Murray)—sponsored by the California Medical Association—would amend Business and Professions Code section 805, which currently requires hospital peer review bodies to report a physician's resignation or leave of absence "following notice of an impending investigation" to the Medical Board's Enforcement Program; such leaves are often taken to enable the physician to enter inpatient drug/alcohol treatment. SB 1045 would convert such reports from section 805 reports to the Enforcement Program into section 821.5 reports to the Diversion Program if a physician takes a leave of absence in order to enter into a drug/alcohol treatment program. Under SB 1045, the Diversion Program manager—upon receiving such a report—is required to "review any ongoing monitoring program...[to] ensure that it is adequate to protect the public, that it includes the requirement that all other hospitals where the physician has privileges are notified of the agreement, and that any violation of the monitoring requirements are reported to the diversion program administrator. *At the discretion of the diversion program administrator, a physician...who repeatedly violates a monitoring agreement may be required to participate in the diversion program of the Medical Board of California.*"⁹³ In other words, the Medical Board's Enforcement Program is deprived of all information about a potentially dangerous drug- or alcohol-abusing physician, and that physician may be given many more "bites of the apple" than he/she is currently entitled to receive.

The Diversion Program is significantly flawed. Because of the secrecy which shrouds the Program, the utter lack of any substantive standards which guide Program decision-making, the Program's own failure to comply with state law requiring comprehensive reporting about its decisions and its cost, and the Division of Medical Quality's wholesale failure to properly oversee the Program, it is impossible for anyone to determine whether Diversion Program protects the public from the state's most dangerous physicians.⁹⁴ Yet that is

exactly what the Legislature has demanded of the Medical Board in Business and Professions Code sections 2229 and 2340. The Legislature should not consider any bill referring more cases to the Program without restructuring the Program and requiring the Division of Medical Quality to take proper and accountable ownership of it. The Medical Board's Diversion Task Force is midway through a comprehensive review of the Program, and should be permitted to complete its work and make its recommendations without having to contend with new changes to the Program. The question for the Legislature is whether to retain the Program within the Medical Board and, if so, how to restructure it; not whether to add new responsibilities to the ones it has proven it cannot handle.

Endnotes

1. See, e.g., *Arnett v. Dal Cielo*, 14 Cal. 4th 4 (1996).
2. G. Douglas Talbott, M.D. and Carolyn Anne Martin, Ph.D., Talbott Recovery Campus, *Relapse and Recovery* (Atlanta, GA; 1999) (on file at CPIL); see also American Society of Addiction Medicine and National Council on Alcoholism and Drug Dependence, *The Definition of Alcoholism* (policy statement approved by NCADD on Feb. 3, 1990; approved by ASAM's Board of Directors on Feb. 25, 1990) (on file at CPIL).
3. Citizen Advocacy Center, *Forum II: To Develop Standards for the Regulatory Management of Chemically Dependent Health Care Practitioners* (Arlington, VA; Mar. 10-12, 1999) (hereinafter "*Forum II*") (keynote address by G. Douglas Talbott, M.D., Medical Director, Talbott Recovery Campus; President, American Society of Addiction Medicine); see also Modlin, H.C. and Montes, A., *Narcotic Addiction in Physicians*, 121 AM. J. PSYCHIATRY 358-65 (1964).
4. Edgar R. Palarea, M.D., *It's Time to Eliminate the "Conspiracy of Silence" Pertaining to Impairment*, 69:3 FEDERATION BULLETIN 75 (Mar. 1982) (the monthly journal of the Federation of State Medical Boards).
5. G. Douglas Talbott, M.D., *Impaired Physicians Program*, 73:3 FEDERATION BULLETIN 69 (March 1986). Dr. Talbott is the founder of and medical director at Talbott Recovery Campus, a nationally-known treatment program for impaired health professionals; he is currently president of the American Society of Addiction Medicine. At a 1999 national conference concerning state diversion programs, Dr. Talbott updated his statistics, opining that 16-17% of physicians (or 1 of 8) will have difficulty with drugs or alcohol at some point in their career. *Forum II, supra* note 3 (keynote address by G. Douglas Talbott, M.D.).
6. American Medical Association Council on Mental Health, *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence*, 223:6 J. AM. MED. ASS'N 684-87 (Feb. 5, 1973), citing Modlin, H.C. and Montes, A., *Narcotic Addiction in Physicians*, 121 AM. J. PSYCHIATRY 358-65 (1964).
7. 14:4 CAL. REG. L. REP. (Fall 1994) at 65.
8. See Julianne D'Angelo Fellmeth, Center for Public Interest Law, *Testimony Before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); Julianne D'Angelo Fellmeth, Center for Public Interest Law, *Testimony Before the Medical Board's Diversion Task Force* (June 3, 1998) (on file at

CPIL); Julianne D'Angelo Fellmeth, Center for Public Interest Law, *Testimony Before the Joint Legislative Sunset Review Committee on the Medical Board of California* (Nov. 17, 1997) at 13-25 (on file at CPIL). See also 14:4 CAL. REG. L. REP. (Fall 1994) at 64-66; 14:2&3 CAL. REG. L. REP. (Spring/Summer 1994) at 67; 14:1 CAL. REG. L. REP. (Winter 1994) at 52.

9. CAL. BUS. & PROF. CODE § 2000 *et seq.*
10. *Id.* at § 2050 *et seq.*
11. *Id.* at § 2018.
12. *Id.* at §§ 2004, 2220 *et seq.*
13. *Id.* at § 2001.
14. *Id.*
15. *Id.* at § 2003.
16. *Id.* at § 2220 *et seq.*
17. *Id.* at § 2230; see also CAL. GOV'T CODE § 12529 *et seq.*
18. CAL. GOV'T CODE § 11370 *et seq.* Within the Office of Administrative Hearings, a special "Medical Quality Hearing Panel" of administrative law judges presides over Medical Board disciplinary matters. *Id.* at § 11371.
19. CAL. BUS. & PROF. CODE § 2335.
20. 16 CAL. CODE REGS. § 1355 *et seq.*
21. CAL. BUS. & PROF. CODE § 2346.
22. *Id.* at § 2340 (emphasis added).
23. *Id.* at § 2229(a), (c) (emphasis added).
24. *Id.* at § 2350(f).
25. *Id.* at § 2350.
26. "Successful completion shall be determined by the [diversion evaluation] committee, but shall include, at a minimum, two years during which the physician...has remained free from the use of drugs or alcohol and adopted a lifestyle to maintain a state of sobriety." *Id.* at § 2350(g).
27. *Id.* at § 2239.
28. *Id.* at §§ 2354, 2350(e).
29. *Id.* at § 2229(c).
30. *Id.* at § 2342.
31. *Id.* at § 2350(a). In 1981, DMQ adopted regulations establishing these criteria; see 16 CAL. CODE REGS. §§ 1357.1, 1357.4, 1357.5.
32. CAL. BUS. & PROF. CODE § 2350(h). DMQ has never established criteria for the selection of "administrative physicians."
33. *Id.* at § 2350(i)). No DEC has submitted such a report since at least January 1994.
34. *Id.* at § 2346.
35. This is true as to self-referred participants, whose identity remains confidential from DMQ. As to a participant who agrees to enter the Diversion Program under stipulation with the Division, the Division could theoretically require the inclusion of certain terms in that Program contract.
36. CAL. BUS. & PROF. CODE § 2342.
37. *Id.*
38. *Id.*
39. *Id.* at § 2352.
40. *Id.* at § 2350(i).
41. Group facilitators are located in the San Diego, San Francisco, the Inland Empire, Los Angeles, Fresno, Bakersfield, and Eureka areas. Telephone Interview with John Lancara,

Acting Program Manager of the Medical Board's Diversion Program (Mar. 5, 1999).

42. Medical Board of California, Diversion Program, *Group Facilitator Policies and Procedures* (Sacramento, CA; June 1993) at 1 (on file at CPIL).

43. *Id.* at 2.

44. Medical Board of California, Diversion Program, *Case Managers Duties and Priorities* (Sacramento, CA; undated) (produced in 1993 in response to a CPIL Public Records Act request) (on file at CPIL).

45. Medical Board of California, Diversion Program, *The Charge to the Liaison Committee to the Medical Board's Diversion Program* (Sacramento, CA; Mar. 30, 1992) (on file at CPIL).

46. *Id.*

47. In recent documents, the Liaison Committee states it has engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the past five years. These activities include a report and recommendation on the Program's urine testing program (Oct. 16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board's Diversion Program, *Testimony before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); *see also* Liaison Committee to the Medical Board's Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

48. 16 CAL. CODE REGS. § 1357.2(b).

49. The author has attended quarterly DMQ meetings on a regular basis since 1986. The only interest DMQ has taken in the Diversion Program during the past decade followed the 1993 release by the California Highway Patrol of its investigation of the Medical Board's enforcement program, in which the CHP made several observations about alleged improprieties committed by staff of the Program. California Highway Patrol, Bureau of Internal Affairs, *Administrative Investigation: Medical Board of California (Investigative Summary)* (Sacramento, CA; Jan. 11, 1993). At that point, DMQ set up a Diversion Task Force, which met several times but then disbanded without making any significant changes in the Program. *See* 14:1 CAL. REG. L. REP. (Winter 1994) at 51-52.

50. *See* examples at note 47.

51. Office of the Auditor General, *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program; Some Problems Remain* (Report No. P-576) (Sacramento, CA; June 1986); Office of the Auditor General, *The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer from*

Alcoholism or Drug Abuse (Report No. P-425) (Sacramento, CA; Jan. 1985); Office of the Auditor General, *Review of the Board of Medical Quality Assurance* (Report No. P-035) (Sacramento, CA; Aug. 13, 1982).

52. Office of the Auditor General, *Review of the Board of Medical Quality Assurance* (Report No. P-035) (Sacramento, CA; Aug. 13, 1982) at 33.

53. Office of the Auditor General, *The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer from Alcoholism or Drug Abuse* (Report No. P-425) (Sacramento, CA; Jan. 1985) at 23.

54. *Id.*

55. *See, e.g.,* Chet Pelton, et al., *Physician Diversion Program Experience with Successful Graduates*, 25(2) J. PSYCHOACTIVE DRUGS 159 (Apr.-June 1993); Chet Pelton and Richard Ikeda, M.D., *The California Physicians Diversion Program's Experience with Recovering Anesthesiologists*, 23(4) J. PSYCHOACTIVE DRUGS 427 (Oct.-Dec. 1991); Richard Ikeda, M.D., M.P.A. and Chet Pelton, *Diversion Programs for Impaired Physicians*, 152 WESTERN J. OF MEDICINE 617 (May 1990).

56. At each quarterly meeting of DMQ, the Diversion Program distributes a skeletal data sheet with the latest Diversion Program statistics and cumulative totals dating since 1980. The author has witnessed numerous DMQ members questioning Diversion Program staff as to the whereabouts of former Program participants who have "terminated unsuccessfully"; no answers are ever forthcoming.

57. *See infra* text at notes 87-88.

58. Note that the DEC's have no disciplinary authority in that they are not authorized to suspend, revoke, or restrict a participant's license to practice medicine. At most, a DEC may decide to include a "practice cessation" provision in a participant's Diversion Program contract; if the participant refuses to accept the provision, the DEC may deny admission into the Program, thus exposing the licensee to potential disciplinary action under Business and Professions Code section 2239. Even if an applicant agrees not to practice medicine, the Diversion Program has no meaningful monitoring mechanism to ensure that physicians who have agreed to stop practicing medicine have in fact stopped. Additionally, any such requirement not to practice is not communicated to the Medical Board's Enforcement Program, and is not disclosed to a consumer inquiring about the physician's disciplinary record. *See infra* text at notes 69-70.

59. CAL. BUS. & PROF. CODE §§ 2350(g), 2355.

60. Although Diversion Program staff assert that the DEC's decide whether and when to terminate a participant from the Program, no statute expressly permits a DEC to terminate a Diversion Program participant for noncompliance with the terms of the Program contract. DMQ's regulations purport to authorize the DEC's to terminate a physician's participation in the program for a variety of reasons, 16 CAL. CODE REGS. § 1357.5; however, the legislative authority underlying these regulations is implied rather than expressed.

61. 2 CAL. JUR. 3D *Administrative Law* § 40 (1995).

62. *See generally* 16A AM. JUR. 2D *Constitutional Law* § 378 (1998) ("[s]ince generally the legislature may not

delegate its legislative powers to private individuals, associations, or corporations, *the legislature is without authority to delegate the exercise of police powers to a private corporation or private citizen...., particularly where there is no state supervision*") (emphasis added). See also *Bayside Timber Company, Inc. v. Board of Supervisors of San Mateo County*, 20 Cal. App. 3d 1 (1971) (statutory scheme establishing regional forest practice committees composed primarily of private timber owners and requiring them to both draft the state Board of Forestry's logging regulations and secure their approval by two-thirds of the private timber owners in each district before they become effective invalidated as standardless delegation of state police power authority to private parties with a vested interest in the content of the rules).

63. 15 U.S.C. § 1; CAL. BUS. & PROF. CODE § 16700 *et seq.*

64. *Associated Press v. United States*, 326 U.S. 1 (1945).

65. *Parker v. Brown*, 317 U.S. 341 (1943).

66. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980) (hereinafter "*Midcal*"); see also *Federal Trade Comm'n v. Tico Title Insurance Co.*, 504 U.S. 621 (1992) ("the purpose of the active supervision inquiry...is to determine whether the State has exercised sufficient independent judgment and control....The question is not how well state regulation works but whether the anticompetitive scheme is the State's own").

67. In fact, Business and Professions Code section 2352 may not "articulate" the authority of the DEC's to determine the terms and conditions of a Diversion Program participant's contract as "clearly" as the Medical Board may think it does. Section 2352(e) authorizes a DEC to "consider"—not necessarily decide—whether a physician participant "may with safety continue or resume the practice of medicine." Section 2352(f) permits a DEC to "set forth in writing" a "treatment program...for the requirements for supervision and surveillance." Neither of these statutes clearly authorizes the DEC's to determine unilaterally, without review or ratification by DMQ or a Medical Board employee, the terms and conditions under which a physician may practice medicine. Thus, the DEC's decisionmaking may not even satisfy the first required prong of the *Midcal* test, and it clearly does not satisfy the second required prong; see text following note 68.

68. *Midcal*, *supra* note 66.

69. At each quarterly DMQ meeting, the Diversion Program distributes a two-page statistical data sheet indicating, among other things, the number of current participants in the Program. As of September 30, 1998, a relatively high number of 231 physicians were enrolled in the Program; as of September 30, 1997, 217 physicians were in the program; as of September 30, 1995, 205 physicians were in the program (all reports on file at CPIL). See also 15:1 CAL. REG. L. REP. (Winter 1995) at 63–64 (MBC member Milkie questions why average number of Diversion Program participants has remained constant at 220–240 for fifteen years).

70. See *supra* note 51.

71. The Medical Board of California currently licenses over 104,000 physicians. Using the most conservative of the lifetime prevalence estimates presented above, see *supra* notes

4–6, at least 10,000 California-licensed physicians will experience chemical dependency at some point in their careers. Over the past twenty years (the approximate age of the Diversion Program and approximately one-half the length of a physician's career), the Board probably averaged 70,000 licensees, such that—statistically—3,500–4,000 physicians actually experienced drug or alcohol addiction during that twenty-year period.

72. Medical Board of California, *California Physician Diversion Program* (Sept. 30, 1998) (quarterly statistics provided to the Division of Medical Quality) (on file at CPIL).

73. See 15:1 CAL. REG. L. REP. (Winter 1995) at 63–64.

74. In the contract used by the Board of Registered Nursing for entry into its diversion program, the applicant must agree to "cease the practice of nursing until my assessment process is completed, this agreement is signed and returned, and I have received an addendum to this agreement following [diversion program contractor] consultation with the Diversion Evaluation Committee." Board of Registered Nursing, *Diversion Program Entry Agreement* (Nov. 30, 1992) (on file at CPIL). This "practice cessation" is not a formal suspension, but an agreed-to interruption in practice during evaluation, treatment, and the early stages of recovery; the nurse may not resume practice until authorized by the Diversion Evaluation Committee. See also 13:2&3 CAL. REG. L. REP. (Spring/Summer 1993) at 106–07.

75. For example, New York requires a participant to temporarily surrender his/her license upon entry into its Diversion Program. N.Y. PUB. HEALTH LAW § 230(13)(a). Pennsylvania requires participants to sign a "consent agreement" in which they agree to cease practice during evaluation and treatment. *Forum II*, *supra* note 3, at Part IV (Assorted Contractual Forms) (Pennsylvania Bureau of Professional and Occupational Affairs, Consent Agreement and Order) (on file at CPIL).

76. With regard to standards of debilitation warranting practice cessation, the Program appears to operate on an "I know it when I see it" philosophy; see *Jacobellis v. Ohio*, 378 U.S. 184 (1964) (Stewart, J., concurring) ("I shall not today attempt further to define the kinds of material I understand to be embraced within [the definition of obscenity]; and perhaps I could never succeed in intelligibly doing so. But I know it when I see it...."). By virtue of its absence, DMQ vests absolute confidence and discretion in the ability of the other "players" to recognize debilitating chemical dependency and demand a practice cessation.

77. When confronted with this concern at a July 1994 meeting, Diversion Program staff insisted that the group facilitators who conduct weekly meetings will somehow be able to discern that a physician has been practicing medicine, and that the participant's case manager "knows where the physician has practiced and hopefully where the doctor has privileges." See 14:4 CAL. REG. L. REP. (Fall 1994) at 66.

78. 16 CAL. CODE REGS. 1357 *et seq.*

79. Medical Board of California, *Diversion Program, Third Annual Report* (Sacramento, CA; 1996) at 3; see also Medical Board of California, *Diversion Program, Second Annual Report* (Sacramento, CA; 1995) at 4.

80. Medical Board of California, *Diversion Program*,

Third Annual Report (Sacramento, CA; 1996) at 6.

81. Medical Board of California, Diversion Program, *Second Annual Report* (Sacramento, CA; 1995) at 8.

82. Medical Board of California, Diversion Program, *Orientation of Board Members* (Sacramento, CA; July 27, 1994) at 2.

83. The Diversion Program is clearly not a treatment program for drug/alcohol abuse, in that it does not directly provide treatment (other than the counseling provided by group facilitators at meetings). Whether it provides "therapy" through twelve-step counseling by group facilitators is unclear; if it does, the Medical Board is authorizing the unlicensed practice of therapy because it does not require its group facilitators to be licensed therapists. At most, it is a monitoring program: It purports to monitor a participant's compliance with the terms of the contract which the participant has signed with the Program. Through the contract (and the threat of license discipline for noncompliance with the contract), the Diversion Program requires each participant, on a case-by-case basis, to seek specified treatment and engage in specified rehabilitation programs, including attendance at its own group meetings.

84. Medical Board of California, Diversion Program, *Group Facilitator Policies and Procedures* (Sacramento, CA; June 1993) at 2 (on file at CPIL).

85. CPIL brought this issue to the attention of the Diversion Program in May 1993. At that time, a task force of the Board reviewing the Diversion Program indicated that "the current facilitators should be allowed to continue with the Diversion Program even though they are not licensed therapists or certified drug counselors; however, the current facilitators who do not meet those criteria should obtain ten hours of credit each year that could be used toward obtaining a certificate or license." However, all Diversion Program group facilitators had not met these criteria by 1995. In a report to the Board's Division of Medical Quality, the Diversion Program noted: "The five (5) facilitators who lacked either a therapy license or a CADAC Certificate have been progressing toward their certificate or therapy license. We expect the identified facilitators will obtain their certificate or license by August 1996." Medical Board of California, Diversion Program, *Second Annual Report* (Sacramento, CA; 1995). No follow-up on the licensure status of these facilitators was provided in the Diversion Program's *Third Annual Report* (1996) or any Diversion report thereafter.

86. California Highway Patrol, Bureau of Internal Affairs, *Administrative Investigation: Medical Board of California (Investigative Summary)* (Sacramento, CA; Jan. 11, 1993) at 25.

87. As noted above, Business and Professions Code section 2350(g) requires two years of sobriety. However, the Diversion Program's quarterly reports to DMQ from September 30, 1997 through September 30, 1998 state: "To complete successfully means that the Diversion Evaluation Committee is satisfied that the participant has been clean and sober for a minimum of 3 years...." No regulation duly adopted by DMQ has enhanced the statutory requirement to three years. This may be another example of Diversion Program staff implementing a Liaison Committee recommendation

without consulting DMQ; it is also a clear case of underground rulemaking in violation of the Administrative Procedure Act (APA), Government Code § 11340 *et seq.*, in that it implements a statute and has not been adopted pursuant to the rulemaking procedures required by APA.

88. Citizen Advocacy Center, *Forum on the Regulatory Management of Chemically Dependent Health Care Practitioners* (Arlington, VA; Mar. 5-6, 1998).

89. Other states require diversion program participants to sign a relapse management contract as part of admission into their programs. These states use forms which require detailed documentation of each instance of relapse, and attempt to quantify or objectify the degree of relapse to assist in a determination of Program action. See, e.g., *Forum II*, *supra* note 3, at Part III (Program Descriptions) (Utah Recovery Assistance Program Score Sheet for Lapse/Relapse; Oregon Diversion Program for Health Professionals Protocol for Relapse Management).

90. In 1985, the Auditor General phrased this goal more simply: "Finally, to improve the medical board's oversight of the diversion program, the medical board should develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly." Office of the Auditor General, *The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer from Alcoholism or Drug Abuse* (Report No. P-425) (Sacramento, CA; Jan. 1985) at 32. Fourteen years later, the Medical Board has still failed to implement this recommendation.

91. "The diversion program administrator shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of the investigation is not adequate to protect the public, the diversion program administrator shall notify the Chief of Enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter." CAL. BUS. & PROF. CODE § 821.5(b). However, if the peer review body closes the investigation and "has determined that there is no need for further action to protect the public, the diversion program shall purge and destroy all records in its possession pertaining to the investigation...." *Id.* at § 821.5(e).

92. Medical Board of California, *1997-98 Annual Report* (Sacramento, CA; Oct. 1998) at vii.

93. Senate Bill 1045 (Murray), as introduced February 26, 1999 (proposed amendments to Business and Professions Code section 821.5(c)) (emphasis added).

94. The Program's supporters frequently state that "no patient has ever been injured by a Diversion Program participant" and that "Diversion Program graduates are disciplined less frequently than the general population of physician licensees." We don't know that. No one knows that. No one—not the Program's supporters, not the Medical Board's Enforcement Program, not the victims of injury caused by Diversion Program participants or graduates, and not this author—knows who is or has been in the Diversion Program. These claims are meaningless and misleading.